Mark A. Hackel
County Executive

Macomb County Community Mental Health

FOCUS

Acknowledgment And Consent Form

IDENTIFYING INFORMATION			
NAME	CASE #	DOB	GENDER
ADDRESS			

PROVIDED INFORMATION

DOCUMENT DATE

Consumer was provided with the following information:

Membership Information

- ☐ 1. MCCMH Membership Handbook, "Help When You Need It" provided
- ☐ 2. "Your Rights When Receiving Mental Health Services in Michigan" provided
- ☐ 3. "MCCMH Notice of Privacy Rights" provided
- ☐ 4. For adult consumers, Advance Directive information provided
- ☐ 5. All of the above information given to consumer

Consumer Orientation

☐ 1. The consumer was informed about MCCMH policy with regards to use of tobacco products, illegal or legal drugs, prescription medication, and weapons brought into the program

- ☐ 2. The consumer was oriented to the building/facility
- ☐ 3. Discharge criteria was explained to the consumer
- ☐ 4. Other:

Notification of Release of Information to the Michigan Department of Community Health (MDCH)

☐ 1. Consumer provided with this form and verbal explanation of use of Social Security Number to provide MDCH with statistical information.

Informed Consent for Service

- ☐ 1. Evaluation and Assessment
- ☐ 2. Clinical Services
- ☐ 3. Supports Coordination / Client Services Management
- ☐ 4. Psychosocial Rehabilitation Services
- ☐ 5. Suport Services

Fee Determination Agreement / Consumer Insurance Authorization

- ☐ 1. Consumer provided information related to the setting of a monthly fee.
- ☐ 2. Consumer provided information about and agrees to coordination of benefits and communication with consumer's health insurer or its intermediaries or carriers.

Provider Panel Listing

- ☐ I have received a paper copy of the MCCMH Provider network list.
- ☐ I refused a paper copy and will access the MCCMH Provider network list from www.mccmh.net

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My signature on this form acknowledges receipt of the material indicated by check mark, this Acknowledgment and Consent Form and Notification for Release of Information to MDCH, if I have not previously received them. My signature further documents that the services to be provided, fees to be charged for those services and process for communication with my health insurer(s) have been explained to my satisfaction. I consent to receive these services provided at the established fee and to communication between my provider and my health care insurer as described in the Fee Determination Agreement / Insurance Authorization.

As a consumer / parent / guardian, I understand the rationale for the procedures, risks, consequences, and other relevant factors. I have been provided with an explanation of the program procedures, a description of the potential risks and discomforts that might be experienced, a description of the potential benefits of the program, and answers to inquiries concerning the program and alternative programs, if any. I acknowledge receipt of the “Rights Brochure” that outlines my rights as a consumer of Mental Health services.

The services which will be provided have been explained to my satisfaction by:

INFORMED CONSENT FOR SERVICE

This consent expires on: or whenever interim circumstances or changes in the treatment plan substantially affect the risks or other consequences or benefits reasonably to be expected, or at least annually or when rescinded by the consumer / parent / guardian. I realize that I may withdraw consent and discontinue treatment at any time without prejudice, and I may require other types of treatment.

- ☐ Consumer / parent / guardian was unable to sign the informed consent
- ☐ Consumer / parent / guardian was unwilling to sign the informed consent
- ☐ Informed consent was read to consumer / parent / guardian
- ☐ Oral explanation of informed consent was made to consumer / parent / guardian in a language other than English which was understandable to the individual
- ☐ Other (describe):

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TYPE OF SERVICES	
Evaluation and Assessment	May include personal interview, standardized assessments, psychiatric evaluation, psychological testing, nutritional assessment, vocational assessment, speech / language assessment, behavioral assessment, mental status exam, psychosocial assessment, occupational therapy assessment, health care assessment.
Clinical Services	May include group therapy, individual therapy, conjoint therapy, family therapy, child therapy, medication review, enhanced health care services, crisis intervention.
Supports Coordination / Client Services Management	May include activities of assessment and service planning, linking, monitoring, and advocacy to ensure that appropriate services are delivered to the individual consumer.
Psychosocial Rehab. Services	May include Assertive Community Treatment, Clubhouse Activities, Vocational Services, Educational Services.
Support Services	May include Community Living Supports,Transportation, Family Support Services, Respite Care, Housing Assistance, Personal Care in Licensed Settings, Skill Building Sssistance, Environmental Modification, Assistive Technology, Family Skills Development, Chore Services, Pharmacy, Equipment and Supplies.

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INSTRUCTIONS FOR THE USE OF MCCMH #289, ACKNOWLEDGMENT AND CONSENTS

A. Relevant portions of this document must be completed:

1. At the time of the initial assessment irrespective of whether the consumer will receive subsequent services from the MCCMH Board.

2. Annually at the time that consent for service and financial liability determination are to be updated.

B. All items contained on this form are to be verbally discussed with the consumer / parent / guardian prior to requesting his / her signature. The consumer's / parent's / guardian's questions and concerns are to be solicited and addressed.

C. The Provided Information section of this document is required to be completed at the initial assessment irrespective of whether the consumer will be receiving services. Items given to the consumer / parent / guardian are to be checked. This section is repeated annually.

D. Notification of the release of information to the Michigan Department of Community Health is to be provided verbally by the clinician completing this form with the consumer at the time of the initial assessment. It is required even if the consumer will be receiving no additional services. It does not need to be repeated annually. One might say:

> "Because public funds administered through the Michigan Department of Community Health are being used to support a portion of the cost of your services, we are required to report demographic and service use data to the Department using your Social Security number. This information does include your diagnosis and the kinds of services which are included in your service plan. It does not include information about the content of your therapy sessions or other interactions with CMH staff members."

E. The Fee Determination Agreement / Insurance Authorization form must be completed annually for all consumers who will receive services subsequent to the initial assessment. The process for determining financial liability is detailed in MCCMH MCO Policy 7-001, "Determination of Financial Liability." (Additional procedures for directly-operated providers are outlined in MCCMH MCO Policy 10-060, "Financial Liability Procedures.")

F. The Informed Consent for Treatment section of the form must be completed at least annually for all consumers who will receive services subsequent to the initial assessment. Definitions of the various service categories are found on page 2 under "Type of Services". The process for determining that the consumer is competent to provide informed consent and for discussing the nature of the specific consent which is being requested of an individual consumer / parent / guardian are contained in MCCMH 9-600, "Informed Consent for Service."

G. The expiration date on page two must be completed and may not be more than 365 days in the future. The time frame may be shorter than one year depending upon the circumstances of the consumer and the length of his / her requested or planned service.

H. The signature requirements are unchanged from the existing consent policy.

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SIGNATURES

STAFF SIGNATURE/CREDENTIALS _____ DATE _____

CONSUMER SIGNATURE	PRINTED NAME	DATE
PARENT SIGNATURE	PRINTED NAME	DATE
GUARDIAN SIGNATURE	PRINTED NAME	DATE
WITNESS 1 SIGNATURE	PRINTED NAME	DATE
WITNESS 2 SIGNATURE	PRINTED NAME	DATE